

CLAIMANT'S NAME			SSN OR EMPLOYEE NUMBER*		DEPARTMENT	
Stephen W. Mayberg			461-500-1641-001		Mental Health	
POSITION		CBID	DIVISION OF BUREAU			INDEX NUMBER
Director		E99	Director's Office			461-500
RESIDENCE ADDRESS*			HEADQUARTERS ADDRESS			TELEPHONE NUMBER
on file			1600 Ninth Street			654-2309
CITY		STATE	ZIP CODE	CITY		STATE
				Sacramento		CA
						95814

[illegible]

(11) PURPOSE OF TRIP, REMARKS, AND DETAILS (Attach receipts/vouchers when required)

<p>3/9 - Director to preside at Vacaville Psychiatric Program Governing Body meeting.</p>	<p>(12) Normal Work Hours 8:00 a.m. to 5:00 p.m.</p> <p>(13) Pvt Vehicle License #</p> <p>On file</p> <p>(14) Mileage Rate Claimed</p> <p># ### 0.5</p> <p>ONLY</p> <p>Paid by Revolving Check Number</p>
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I HEREBY CERTIFY that the above is a true statement of the travel expenses incurred by me in accordance with existing agreements and Department of Personnel Administration regulations, in the service of the State of California and that all items shown were for the official business of the State of California, and if a privately-owned vehicle was used, I have met the requirements as prescribed by S.A.M. Sections 0751, 0752, 0753, and 0754 pertaining to vehicle safety and seat belt usage.

CLAIMANT'S SIGNATURE ▷	DATE	(16) SIGNATURE OF OFFICER APPROVING TRAVEL AND PAYMENT ▷	DATE
(17) SIGNATURE AND TITLE OF AUTHORITY FOR SPECIAL EXPENSES ▷			DATE